

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155794		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/11/2014	
NAME OF PROVIDER OR SUPPLIER STRATFORD RETIREMENT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032			
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: April 7, 8, 9, 10, and 11, 2014</p> <p>Facility number: 011151 Provider number: 155794 AIM number: N/A</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Gloria Bond, R.N.</p> <p>Census bed type: SNF--13 Residential--29 Total--42</p> <p>Census payor type: Medicare--9 Other--33 Total--42</p> <p>Residential sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on April 16, 2014.</p>		F000000				
F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Based on observation, interview and record review, the facility failed to ensure staff members were knocking on the residents' doors and waiting to receive permission before entering the room. In addition, the facility failed to ensure a resident was dressed in pants that were in good repair and did not expose any of his body. This deficiency affected 4 of 13 residents reviewed for dignity. (Residents #21, #5, #31, and #17)</p> <p>Findings include:</p> <p>1. In an interview on 4/7/14 at 11:30 A.M., Resident #21 indicated staff "just come into the room and don't really knock." He indicated the way the room was designed, his bedroom section did not have an actual door, just a wide opening between the walls. He stated "Staff and visitors just barge in sometimes." During the interview, LPN #2 came into the room without knocking at the hall doorway, or at the resident's entry area.</p> <p>On 4/7/14 at 12:05 P.M., LPN #2 was observed to walk into the hall doorway, but did not knock there, or at the entry way to the resident's room area. The resident was observed to be in bed in his bedroom at that time.</p> <p>On 4/7/14 at 2:48 P.M., the Activity Director was observed walking in and out of multiple resident rooms, including Resident 21's room, without knocking on the doors.</p> <p>On 4/9/14 at 10:56 A.M., an unidentified CNA went into the room without knocking. She came back out after 15 seconds, carrying</p>			F000241	<p><u>What corrective action will be taken by the facility?</u> Education with all healthcare staff initiated 4/9/14 on Privacy and Dignity with emphasis on resident appearance and knocking on doors. Education will be completed by 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. All healthcare staff will be educated on resident privacy and dignity. All new hires will be educated during general orientation and then annually thereafter. <u>What measures will be put into place to ensure the practice does not recur?</u> The Social Service Director will observe 3 residents daily 5 times per week to ensure staff knocked on doors and resident appears clean and well groomed. She will bring any identified issues to the next morning scheduled interdisciplinary management meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator and Social Services Director will bring the results of the reviews to the monthly QA Committee meeting for review and</p>		05/05/2014

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	<p>foot pedals of a wheelchair. The resident residing in the "A" bed was not in the room; Resident #21 was in his section/room.</p> <p>On 4/9/14 at 11:04 A.M., LPN #2 was observed to walk into the room without knocking, to see if resident was in his room in order to give him medications. The resident was observed in his bed in his room at that time.</p> <p>On 4/9/14 at 11:08 A.M., an unidentified therapy staff knocked lightly on the outside door, but was walking into the room as she did so. She did not wait for anyone to respond.</p> <p>On 4/9/14 at 11:15 A.M., an unidentified staff person went into the room without knocking, and then came back out. The resident was observed to be in his bed in his room.</p> <p>On 4/9/14 at 12:53 P.M., an unidentified therapy staff entered the room without knocking on the door. The resident was in the room.</p> <p>On 4/9/14 at 1:16 P.M., two CNAs took a Hoyer mechanical lift into the room to use to put the roommate into his recliner chair. Neither knocked on the door before going into the room.</p> <p>The clinical record for Resident #21 was reviewed on 4/9/14 at 10:29 A.M. Diagnoses included, but were not limited to, orthostatic hypotension, history of vocal cord dysfunction/esophageal stricture, dysphagia (Strict NPO--nothing by mouth), PEG (percutaneous endoscopic gastrostomy) tube, and Parkinson's disease.</p>				<p>recommendations. Any recommendation made by the committee will be followed up by the Administrator and Social Service Director and the results will be brought to the next schedule QA Committee meeting. This will be monitored for 3 months or until a pattern of compliance is established beginning 5/6/14.</p>		

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	<p>The quarterly MDS (Minimum Data Set) assessment, dated 3/14/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "13" (with 13 to 15 indicating cognitively intact).</p> <p>2. On 4/7/14 at 2:39 P.M., LPN #2 was observed to walk into Resident 5's room without knocking on the hallway door. The nurse left after being in the room about 5 minutes, and then returned again at 2:49 P.M., entering the room without knocking on the hallway door. The resident was observed to be the room at both times.</p> <p>On 4/7/14 at 2:48 P.M., the Activity Director was observed walking in and out of multiple resident rooms, including Resident 5's room, without knocking on the hall door. Resident #5 was observed to be in the room at the time.</p> <p>The clinical record for Resident #5 was reviewed on 4/10/14 at 10:25 A.M. Diagnoses included, but were not limited to, dementia without behavior disturbance, atrial fibrillation, muscle weakness, difficulty walking, recent right embolic stroke with embolectomy and mild residual left hemiparesis, and dysphagia with PEG (percutaneous endoscopic gastrostomy) tube.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 2/17/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "02" (with 0 to 7 indicating severe cognitive impairment).</p> <p>3. On 4/07/2014 at 11:40 A.M., Resident #31 was sitting in his bed. CNA # 4 opened the</p>						

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F000282 SS=E	<p>resident's door, knocking as she walked in. She did not wait for permission to enter.</p> <p>During medication pass on 4/9/14 at 11:00 A.M., LPN #2 was observed to walk into Resident #31's room without knocking or announcing himself.</p> <p>4. On 4/10/14, Resident #17 was observed sitting in the activity room watching television as well as the dining room for breakfast. The resident had a gray pair of sweatpants on. The upper left hip area had a large hole, the resident's under garments were observed through the hole.</p> <p>In an interview on 4/10/14 at 10:10 A.M., CNA # 5 indicated the night staff had gotten him dressed and put these pants on.</p> <p>3.1-3(t) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow physician orders or plan of care interventions, related to falls, showers, or medications, for 4 of 37 residents reviewed for physician orders and plan of care interventions. (Residents #5, #16, #19, and #21)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #5 was reviewed on 4/10/14 at 10:25 A.M.</p>			F000282	<p><u>What corrective action will be taken by the facility?</u> Resident #5 – all vital signs have been obtained and utilized for medication administration per MD orders with hold parameters. For general shift vitals, specific times of vital signs taken will be recorded on "vitals record" when vitals obtained. Nursing staff will be educated by 5/5/14. Resident #21 – was asked if he would like to change the time of his shower to which he declined. He will</p>		

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	<p>Diagnoses included, but were not limited to, dementia without behavior disturbance, atrial fibrillation, recent right embolic stroke with embolectomy and mild residual left hemiparesis, dysphagia with a PEG (percutaneous endoscopic gastrostomy) tube, hypertension, and congestive heart failure.</p> <p>The April, 2014 physician's order recap (recapitulation) sheet included the following order:</p> <p>2/11/14--Metoprolol (an anti-hypertensive medication) 25 mg. (milligrams), one tablet by PEG tube 2 times a day; ***Hold for SBP [systolic blood pressure] < [less than] 110 or HR [heart rate] < 60." The medication was scheduled for 9 A.M. and 9 P.M.</p> <p>The February, March, and April, 2014 MAR (Medication Administration Record) listed this order as prescribed, including the parameters for holding the medication if the systolic blood pressure was less than 110 and heart rate less than 60. The medication was first administered on 2/12/14 at the 9 A.M. dose.</p> <p>There were no blood pressures or heart rates documented on the MARs.</p> <p>The "Vital Signs and Weight Record" had documentation of blood pressures, temperatures, pulses, and respiration rates from 2/10/14, when the resident was admitted, to 4/10/14.</p> <p>There were no blood pressure measurements documented for March 6, 7, 12, and 26. There were 21 days that had only one entry for a blood pressure. Of the 88 blood pressure measurements that were</p>		<p>continue to be offered showers Tuesday, Thursday and Saturday on day shift. The CNA will notify their nurse of continued refusal for further documentation. All nursing staff will be educated on ADL coding and refusal documentation by 5/5/14.</p> <p>Resident #16 – care plan for this resident has been updated to reflect most current fall interventions. These fall interventions have been added to the CNA assignment sheet. All nursing staff will be educated regarding the location of fall interventions and the importance of all of them by 5/5/14. Resident #19 – Kepra and Potassium available at this time. All licensed nurses will be educated to circle medication when not available and utilize back of MAR to indicate why and what they did about it b 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. Charts have been reviewed to ensure current medications are available; fall interventions are in place; weights and vital are being obtained per MD orders. Audits completed 4/23/14. <u>What measures will be put into place to ensure the practice does not recur?</u> The DON or RCD will audit vitals for the completion, timelines and</p>				

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	<p>documented, 85 listed the time frame the blood pressure was checked as either "7 AM-7 PM" or 7 PM-7 AM." There was no indication the resident's blood pressure had been checked prior to the administration of the Metoprolol at 9 A.M. or 9 P.M., in order to know if that dose of medication needed to be held.</p> <p>There were 13 blood pressure measurements listed on the "Vital Signs" sheet that met the "Hold" parameters, as follows:</p> <p>2/12/14--102/70 2/14/14--90/61 2/15/14--102/76 2/18/14--107/68 2/22/14--93/61 2/28/14--97/61 3/1/14--107/68 3/16/14--89/66 3/16/14--100/60 3/28/14--107/74 4/3/14--98/63 4/6/14--102/63</p> <p>The MAR had one entry on 2/14/14 that appeared to be circled, indicating the medication had not been given. An entry on the reverse side for that dated indicated "G-Tube Metoprolol 25 mg. held due to BP [blood pressure]." The entry was crossed out, and "error" with a nurse's initials were written at the end of the entry.</p> <p>All other doses of the Metoprolol were administered on the days the resident's blood pressure, at some time during the day or evening, was below the "Hold" parameter of 110 for a systolic blood pressure.</p>		<p>their use with MD hold parameters 5 days per week. MARS will be audited 5 days per week for medications not available to ensure proper follow-up was completed. Fall interventions will be monitored to ensure they match with the care plan and C.N.A assignment sheets will be monitored 5 days per week. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the reviews to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee meeting. This will continue for 3 months or until a pattern of compliance is established beginning 5/6/14.</p>				

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	<p>During an interview on 4/10/14 at 10:22 A.M., LPN #3 indicated blood pressure measurements would be documented on the "Vital Sign Sheet." She indicated she checks the resident's blood pressure before she gives the BP medication. She did not, however, document the actual time she checked the blood pressure, but just documented that it was taken on the "7 A to 7 P" shift.</p> <p>2. During an interview on 4/07/14 at 11:30 A.M., Resident #21 indicated he received one shower a week. The rest of the week, he takes a "sponge bath" at the bathroom sink, with help from the staff. The resident indicated he really would like to have two showers a week, but had not said anything to anyone about it.</p> <p>The clinical record was reviewed on 4/9/14 at 10:29 A.M. Diagnoses included, but were not limited to, lower extremity deep vein thrombosis, orthostatic hypotension, congestive heart failure, history of vocal cord dysfunction/esophageal stricture, rheumatoid arthritis, dysphagia with strict NPO (nothing by mouth), and severe Parkinson's disease.</p> <p>The "Skilled Nursing Assignment Sheet" form listed the resident's name, with showers to be given on Tuesday, Thursday, and Saturday, on the day shift.</p> <p>In an interview on 4/9/14 at 2:00 P.M., LPN #1 indicated that this schedule was correct, that the resident was to receive a shower three times a week.</p> <p>The "CNA--ADL [Activity of Daily Living] Tracking Form" sheets had the following documentation related to the resident's</p>						

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	<p>showers:</p> <p>January 1 through 7--showers were documented for Wednesday, 1/1; Sunday 1/5; and Monday, 1/6. All showers were documented as given on the day shift.</p> <p>January 8 through 14--showers were documented for Wednesday evening shift, 1/8; Friday, 1/10; and Tuesday, 1/14.</p> <p>January 15 through 21--showers were documented for Thursday, 1/16; and Sunday, 1/19.</p> <p>January 22 through 31--there were no showers documented.</p> <p>February 1 through 7--one shower was documented for Tuesday, 2/4.</p> <p>February 8 through 14--showers were documented on Saturday evening shift on 2/8, and day shift on Sunday, 2/9.</p> <p>February 15 through 21--showers were documented for Saturday, Tuesday, and Thursday 2/15, 18, and 20.</p> <p>February 22 through 28--showers were documented on Saturday and Tuesday, 2/22 and 25.</p> <p>March 1 through 7--showers were documented on the day shift on Saturday 3/1 and the evening shift of the same day, Saturday 3/1.</p> <p>March 8 through 14--showers were documented on Tuesday and Friday, 3/11 and 14.</p>						

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	<p>March 15 through 21--showers were documented for Tuesday, Thursday, and Friday, 3/18, 20, and 21.</p> <p>March 22 through 31--showers were documented for Thursday and Saturday, 3/27 and 29.</p> <p>During an interview on 4/10/14 at 10:13 A.M., the Director of Nursing Services indicated she had spoken with several of the CNAs about the resident's showers. She indicated the CNAs reported the resident occasionally refused a shower, typically in the morning. The resident tended to not feel well in the mornings, so she was going to see about changing the time of his shower to the evenings. She indicated there was no key code for the "CNA--ADL Tracking Form" to indicate a refusal for a shower, but the CNAs were allowed to use an "R" for "refused."</p> <p>The "CNA--ADL Tracking Form" log had an "R" for "refused" on Saturday 1/4/14, and Saturday, 3/8/14.</p> <p>3. On 4/10/14 at 10:45 A.M., the record review for Resident #16 was completed. Diagnoses included, but were not limited to, atrial fibrillation, stroke, macular degeneration, depression and high blood pressure.</p> <p>The Admission Evaluation was completed on 1/27/14, indicated the resident was confused at times. A Fall Risk Assessment dated 1/27/14, indicated a "14" which was considered high risk. The resident vision, continence status, transfer status, as well as health status, contributed to her being high risk.</p>						

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	<p>The resident MDS (Minimum Data Set) assessment dated 2/6/14 indicated the resident was moderately cognitively impaired.</p> <p>The nurses notes dated 3/23/14, indicate the resident was alert and oriented x 3 with confusion at times.</p> <p>A Care Plan Review dated 2/13/14, indicated, "...mobility via wheelchair has visual impairment, walking with assistance from the staff. Walker is used with staff only. No walker use in room. Family to remove walker from room...Increased confusion...."</p> <p>On 4/10/14 at 9:45 A.M., the resident was in her room. The resident was observed to be in the doorway between the common room and her bedroom. There was a sign, posted in the bathroom by the toilet, and taped to her bedside table facing the head of the bed, to remind the resident to use call light before transferring. There was a walker in the living room area between bed A & B with a sticker on it with the resident name on it. She was taken out of her room at 11:05 A.M., by therapy staff.</p> <p>On 4/10/14 at 10 A.M., in an interview LPN # 3, she indicated the current interventions were call light in place and that resident had been working with therapy.</p> <p>On 4/10/14 at 11:25 A.M., in an interview with LPN #1, she indicated the walker in the common area of room was usually only used by therapy, and that it should be removed.</p> <p>4. Resident #19's record was reviewed on 4/9/2014 at 10:00 A.M. Diagnoses included,</p>						

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	<p>but were not limited to, high blood pressure, asthma and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>The resident's current Medication Administration Record (MAR) and April Physician's order recapitulation record, indicated the following medications, were ordered: 12/12/13 the diuretic (water pill) Furosemide 20 mg (milligrams) daily for edema (swelling); 1/26/14 the potassium supplement Potassium Cl ER 10 mEq (milli-equivalent) capsule two times per day; 3/19/14 the anti-convulsant medication Keppra 500 mg two times per day.</p> <p>The MAR indicated on the following dates the resident did not receive the Potassium Cl ER (Extended Release) 10 mEq as ordered: 3/16/14, 3/17, 3/18, 3/19 and 3/20/14. The notation on the back of the MAR indicated the resident did not receive the medication because it was not available.</p> <p>The MAR indicated on the following dates the resident did not receive the anti-convulsant medication Keppra 500 mg two times per day as ordered: 3/19/14, 3/20/14 and 3/21/14. The notation on the back of the MAR indicated the resident did not receive the medication because it was not available.</p> <p>In an interview on 4/9/14 at 10:15 A.M., the DON (Director of Nursing) indicated the Potassium had not been given because there had been some issues regarding the payment of the medication so there was a wait on the medication.</p> <p>A nursing note dated 3/19/14 indicated the medication Keppra had been overlooked and</p>						

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F000314 SS=D	<p>not sent when needed and as ordered.</p> <p>3.1-35(g)(2) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to implement pressure-reducing treatment, devices, and alternate positioning, for 1 of 3 residents reviewed for pressure ulcers. (Resident #21)</p> <p>Findings include:</p> <p>In an interview on 4/7/14 at 11:14 A.M., the Director of Nurses indicated Resident #21 had a Stage 2 pressure ulcer on his upper back, which was acquired in the facility.</p> <p>On 4/7/14 at 11:30 A.M., the resident was observed laying in his bed. The head of bed was elevated 45 degrees. The resident had pillows behind his head, and his upper thoracic back area was flat against the mattress.</p> <p>The clinical record was reviewed on 4/9/14 at 10:29 A.M. Diagnoses included, but were not limited to, history of lower extremity deep vein</p>		F000314	<p><u>What corrective action will be taken by the facility?</u> Resident #21 – pressure ulcer healed 4-22-14. Additional interventions of pressure reduction initiated 4-11-14. No current pressure ulcers on skilled unit. All nursing staff will be educated on pressure reducing interventions for pressure ulcers. They will also be educated on skin condition documentation with their daily nurse note. Education will be completed by 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. Current residents will be assessed for pressure ulcers and have treatment and care plan initiated as needed. <u>What</u></p>			

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	<p>thrombosis, orthostatic hypotension, congestive heart failure, history of vocal cord dysfunction/esophageal stricture, rheumatoid arthritis, dysphagia with strict NPO (no food or fluids by mouth), PEG (percutaneous endoscopic gastrostomy) tube placement; history of pneumonia (likely aspiration), and severe Parkinson's disease.</p> <p>A "Weekly Pressure Ulcer Record" form, dated 4/2/14, indicated the resident had developed an open area on 4/1/14, at the upper middle back, thoracic region. The measurements at that time were 0.5 by 0.1 cm. (centimeter) with a pink wound bed. A wound check on 4/5/14 indicated the measurements were 0.5 by 0.5 by 0.1 cm.</p> <p>There were no Nurses progress notes about the open area.</p> <p>In an interview on 4/9/14 at 10:32 A.M., the resident indicated he got the open sore on his back from scratching himself. He indicated his back got "itchy" from being in bed a lot. The resident indicated he thought the area was now healed. The resident was observed at that time to be sitting in bed with the head of the bed elevated at 45 degrees. He had several pillows behind his head, and his upper back area was flat against the mattress.</p> <p>In an interview on 4/9/14 at 2:15 P.M., LPN #1 indicated she had not been on the unit for awhile, and did not know anything about the pressure sore.</p> <p>In an interview on 4/9/14 at 2:20 P.M., LPN #2 indicated he did not know anything about the pressure sore.</p>		<p><u>measures will be put into place to ensure the practice does not recur?</u> All active pressure ulcers will be audited by DON or RCD 5 times per week for proper interventions and treatments being followed. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and follow-up.</p> <p><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or RCD will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee meeting. This will continue for 3 months or until a pattern of compliance is established beginning 5/6/14.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>In an interview on 4/9/14 at 2:20 P.M., the Director of Nursing indicated the night shift nurse had called her about the area on the resident's back, and asked her to look at it the next day. The resident told the night nurse that he had "scratched" his back, but the DNS was not sure if he could actually reach the area. When she assessed the area, she noticed it was over a bony area, so she identified it as a pressure sore.</p> <p>The April, 2014 physician order recap (recapitulation) sheet included the following orders:</p> <p>2/12/14--Keep HOB (Head of Bed) up > (greater than) 45 degrees for 30 minutes after feeding.</p> <p>4/2/14--Cleanse area to upper back every 3 days and apply 3 X 3 Allevyn dressing until healed and skin is blanchable. (Cleanse with Normal Saline)</p> <p>4/9/14 at 2:33 P.M., LPN #1 was observed to remove the Allevyn dressing on the resident's back. The one she removed was dated "4/5/14." She indicated the physician's order was for the dressing to be changed every 3 days, so the dressing should have been changed on 4/8/14. After she removed the dressing, the open area was observed to be at the side of a thoracic spine vertebra bone. The area was not measured at that time, but appeared to be close to the measurements documented on 4/5/14.</p> <p>On 4/9/14 at 2:49 P.M., the MAR (Medication Administration Record) was reviewed. The order for the Allevyn was listed, and was scheduled to be done on 7A-7P shift. The box for 4/8/14 was outlined as the next scheduled day to change the dressing. The</p>						

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	<p>box was blank. The dressing change was documented as done on 4/9/14 as observed.</p> <p>During an interview on 4/10/14 at 9:45 A.M., the resident indicated the head of his bed is always in an elevated position, so he was usually positioned with his back against the mattress. He indicated he was able to lay on his side somewhat, and was doing so today because he was nauseated, and wanted to be able to lean over the side of the bed to vomit in the trash basket. He indicated he had not received any instructions about staying off of his upper back area so the open area could heal.</p> <p>During an interview on 4/10/14 at 9:50 A.M., the Director of Nurses indicated the resident's open wound area would be tracked weekly on Wound rounds. If it did not improve, she would seek a change in treatment. She was given the opportunity to provide information about other interventions that were in place, which would promote the healing of the open area.</p> <p>A Care Plan entry, dated 12/9/13, addressed a problem of "Risk for Alteration in Skin Integrity." Interventions included, but were not limited to, the following: "Use pillows, pads, or wedges to reduce pressure on heels and pressure points. Turn/reposition; During periods of extended bed rest, remind [resident's name] to turn/reposition self."</p> <p>A Care Plan entry, dated 4/2/14, addressed a problem of "Wound to upper back." There was one intervention of "Treatment as ordered."</p> <p>At the final exit on 4/11/14, no additional documentation/information was provided for</p>						

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F000323 SS=D	<p>review related to other interventions in place to promote the healing of the resident's open area.</p> <p>3.1-40(a)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to implement a fall intervention, related to leaving a walker in reach of 1 resident who required assistance of staff to walk, for 1 resident reviewed for accidents. (Resident #16)</p> <p>Findings include:</p> <p>On 4/10/14 at 10:45 A.M., the record review for Resident #16 was completed. Diagnoses included, but were not limited to, atrial fibrillation, stroke, macular degeneration, depression and high blood pressure.</p> <p>The Admission Evaluation was completed on 1/27/14, indicated the resident was confused at times. A Fall Risk Assessment dated 1/27/14, indicated a "14" which was considered high risk. The resident vision, continence status, transfer status, as well as health status, contributed to her being high risk.</p> <p>The resident MDS (Minimum Data Set) assessment dated 2/6/14 indicated the resident was moderately cognitively impaired.</p>	F000323	<p><u>What corrective action will be taken by the facility?</u> Resident #16 – currently has fall interventions in place which are active on the CNA assignment sheet. All nursing staff will be educated where to find current fall interventions. Licensed nurses will be educated to investigate all falls to ensure interventions in place and educate as needed. Active records will be audited to ensure fall interventions are up to date on care plans and CNA assignment sheet. Date of completion: 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. Records will be reviewed by the DON 5 times per week to ensure that fall interventions are in place and are identified on care plans and C.N.A assignment sheets. <u>What measures will be put into</u></p>				

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F000328 SS=D	<p>The nurses notes dated 3/23/14, indicate the resident was alert and oriented x 3 with confusion at times.</p> <p>A Care Plan Review dated 2/13/14, indicated, "...mobility via wheelchair has visual impairment, walking with assistance from the staff. Walker is used with staff only. No walker use in room. Family to remove walker from room...Increased confusion...."</p> <p>On 4/10/14 at 9:45 A.M., the resident was in her room. The resident was observed to be in the doorway between the common room and her bedroom. There was a sign, posted in the bathroom by the toilet, and taped to her bedside table facing the head of the bed, to remind the resident to use call light before transferring. There was a walker in the living room area between bed A & B with a sticker on it with the resident name on it. She was taken out of her room at 11:05 A.M. by therapy staff.</p> <p>On 4/10/14 at 10 A.M., in an interview LPN # 3, she indicated the current interventions were call light in place and that resident had been working with therapy.</p> <p>On 4/10/14 at 11:25 A.M., in an interview with LPN #1, she indicated the walker in the common area of room was usually only used by therapy, and that it should be removed.</p> <p>3.1-45(a)(1) 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;</p>			<p><u>place to ensure the practice does not recur?</u> All falls will be investigated by DON or RCD to ensure interventions were in place and educate as needed.</p> <p><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or RCD will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee meeting. This will continue for 3 months or until a pattern of compliance is established beginning 5/6/14.</p>			

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	<p>Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure placement was checked prior to medication administration and feeding for a gastrointestinal tube (GT) for 1 of 1 residents in a sample of 2 residents who had gastrointestinal tubes. In addition, the facility failed to provide PICC (Peripherally Inserted Central Catheter) line care for 1 of 1 resident's observed for central line care. (Residents #21 and #32)</p> <p>Findings include:</p> <p>1. On 4/9/14 at 11:00 A.M., the medication pass observation was completed for Resident #21. LPN #2 did not check for placement (listening with a stethoscope to ensure tube was in the stomach) of the GT prior to the giving of GT medications. LPN # 2 placed the syringe into the end of the GT. He poured the mixture of medications with water into the barrel of the syringe, inserted the plunger, and forcefully pushed the medications into the GT. After finishing medications, he gave the tube feeding in the same manner, by placing the tip of the syringe into the end of the GT and pouring the tube feeding into the syringe and pushing the feed into the GT. LPN #2 indicated during an interview at this time, Resident #21's GT will not allow things to flow by gravity so they are having to push the</p>			F000328	<p><u>What corrective action will be taken by the facility?</u> Resident # 21 – does not have any complications of G tube being dislodged. Placement checked by DON 4-11-14. MD notified that G-Tube does go to gravity. Documentation has been requested for next visit. All licensed nursing staff will be educated on G-Tube care and medication administration by 5/5/14. Resident # 32 – had PIC line discontinued 4-21-14. After leaking was noted, PIC line was replaced. No complications occurred thru the duration of her treatment. There are no current PIC lines. All licensed nursing staff will be educated on PIC line flushing and dressing changes by 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. Active records for residents receiving PIC lines and g-tubes will be reviewed to ensure that nursing staff is following established protocol. Date of completion: 4/24/14. <u>What measures will be put into place</u></p>		05/05/2014

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	<p>feedings as well as the medications through the tube.</p> <p>LPN #2 took the remainder of the tube feeding in the can and placed a clean glove over the top of it. LPN #2 indicated he saved the remainder of the tube feeding for the next feeding so he was not wasting tube feeding as it was expensive and he thought this was helpful to the patient. He placed the tube feeding can with the glove over the top of it on the bathroom counter and left it there when he left the resident's room.</p> <p>In an interview with LPN #1 on 4/10/14 at 2:40 P.M., she indicated nurses should check for placement prior to giving any GT medications. A policy was requested at that time.</p> <p>In an interview on 4/10/14 at 2:52 P.M., with the the Director of Nursing (DoN), she indicated the resident had trouble with the GT in the hospital and the hospital had gotten it working and when he came here that was the baseline of the medications and feeding to be pushed through the tube. A request was made for physician order and documentation that the physician was aware that the meds were being pushed through the tube. Any information regarding the physician's awareness was requested at that time. On 4/11/14, at the exit conference, there was no information regarding the physician's awareness of the needing to push feedings and medications provided.</p> <p>On 4/11/14 at 10:00 A.M., the DoN provided the policy "Enteral Feeding : Administration by Syringe Bolus" dated 11/1/12. The policy indicated, "...9. Verify tube position. 9.1 Place stethoscope over patient's epigastric region.</p>			<p><u>to ensure the practice does not recur?</u> All active PIC lines and IVs will be audited 5 times per week to ensure flushes and dressing changes are being performed per policy and MD orders. The DON or RCD will observe 5 days per week to ensure g-tube placement is checked while this service is being provided on the skilled unit. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or RCD will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee meeting. This will continue for 3 months or until a pattern of compliance is established beginning 5/6/14.</p>			

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	<p>9.2 Inject 10 cc air into the tube while listening for whooshing sound...12. Remove the plunger from the syringe and place the tip of the syringe into the feeding tube. 13 syringe and instill by gravity. 14. Slowly pour formula directly into syringe and instill using gravity. Tilt syringe slightly to allow the air bubbles to escape...19. Label (with patients' name and date) and cover any unused tube feeding formula. Place in refrigerator. Discard unused, covered formula after 24 hours...."</p> <p>2. The record review for Resident #32 was completed on 4/10/14 at 10:30 A.M., diagnoses included, but were not limited to, dehydration, dementia, and urinary tract infection.</p> <p>Resident #32 had a physician's order dated 4/3/14 that indicated, "...D51/2 Normal Saline at 50 milliliters and hour for 72 hours..Flushing orders: Use SAS (Saline, Administer medication, Saline) the box was checked for continuous infusion-No flushing required...."</p> <p>A "Vascular Access Insertion Documentation" dated 4/5/14, indicated the resident had the PICC line placed.</p> <p>The resident was sent to the hospital on 4/7/14 to evaluate and treat in the emergency room, she returned with an order to start Cipro (Antibiotic) 400 milligrams every 12 hours per intravenous (IV) method for 7 days due to a urinary tract infection.</p> <p>An observation on 4/9/14 at 1:40 P.M., Resident #16 had an undated clear dressing on her right arm where her PICC line was. LPN # 2 had flushed Resident #32's PICC line and a profuse amount of saline was</p>						

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	<p>observed to come out around the edges of the PICC line dressing. LPN # 2 indicated at that time that the residents PICC line had leaked some yesterday when he flushed it. LPN #2 indicated the PICC line did not leak when he ran the antibiotic.</p> <p>The nurses notes dated 4/8/14 at 1:00 A.M., indicated, "...Midline to right arm intact flush without difficulty started Cipro IV Piggy Back...." There was no documentation in the nurses notes regarding the difficulty in flushing the PICC line mentioned by LPN #2, and no documentation was found that the physician had been notified.</p> <p>The physician's progress notes had no documentation from 4/8/14 regarding concerns with PICC line.</p> <p>The nurses notes indicated, "... 4/10/14 at 5 A.M. the resident had a new PICC line placed around 7 P.M. RN put in PICC line in right arm X-rays done and CIPRO started IV...."</p> <p>On 4/10/14 at 2:00 P.M., the DoN provided a document titled, "Midline Catheter Treatment Record " the document indicated, " minimum flush/unused lumens non-valved catheter every 12 hours each lumen 10 milliliters Normal Saline and 3 milliliters Heparin 10 units per milliter...."</p> <p>On 4/10/14 at 1:08 P.M., the DoN (Director of Nursing) indicated they use the pharmacy's protocol after the continuous fluids were discontinued for Resident #32. She indicated the transparent occlusive dressing that was on yesterday during the afternoon med pass was the same dressing the PICC team had placed on 4/5/14. She indicated the orders for this would be on the MAR and she would</p>						

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F000329 SS=D	<p>get copies of that as well as the pharmacy protocol.</p> <p>On 4/10/14 at 2:00 P.M., the DoN provided a document titled, "Midline Catheter Treatment Record indicated, "...change catheter site dressing weekly...." There was a blank box dated April 12th to change the catheter site dressing.</p> <p>A Care Plan dated 4/6/14 addressing the PICC line care. Interventions included, "...4. Notify MD of difficulty in flushing or signs and symptoms of infection...."</p> <p>The pharmacy policy, dated 1/15/04 with revision dates of 10/05, 3/07, 8/08, and 7/12 indicated, "...Central Venous (CVC) Catheter Dressing Change...Guidance: 1. Sterile dressing change using transparent dressings is performed : 1.1 -24 hours post-insertion or upon admission...."</p> <p>3.1-47(a)(2) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless</p>						

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	<p>antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review the facility failed to adequately monitor a diuretic and antihypertensive (medication for high blood pressure) medication as ordered for 2 out of 5 residents reviewed for unnecessary medications (Resident # 29 and # 17).</p> <p>Findings include:</p> <p>1. Resident # 29's record was reviewed on 4/10/14 at 9:10 A.M. Diagnoses included, but were not limited to, left hip replacement, depression, osteopenia, high blood pressure, glaucoma, and dry eyes.</p> <p>The resident's current Medication Administration Record (MAR) and April Physician's order recapulation record, indicated the following medications were ordered: 3/13/14 the diuretic (water pill) medication Furosemide 20 mg (milligrams) orally once a day at 1 P.M. 3/6/14 the anti-hypertensive medication Lisinopril 10 mg orally once per day for high blood pressure 3/13/14 Furosemide 40 mg every morning.</p> <p>The resident's record titled, "[name of pharmacy] Potential Drug Interactions" and dated 3/21/2014 indicated for Furosemide 40</p>	F000329	<p><u>What corrective action will be taken by the facility?</u> Resident #29 – discharged on 4/19/14 . Prior to resident discharge, Lasix was discontinued per pharmacy recommendation. Resident #5 – remains on unit. Blood pressure being monitored per MD orders. All licensed nurses will be educated to call pharmacy recommendations to physician and document response. Current charts will be reviewed to ensure vitals are being obtained per physician orders. All new pharmacy recommendations will be called to physician. Education will be completed by 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. Current records will reviewed to ensure vitals are being obtained per physician orders. All new pharmacy recommendations will be communicated to the physician. Active records will be audited 5 times per week beginning 5/6/14. <u>What measures will be put into place</u></p>	05/05/2014			

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	<p>mg and Lisinopril 10 mg, "Patient Management : In patients without heart failure, it may be advisable to discontinue the diuretic, reduce the dose of the diuretic, or increase salt intake prior to the initiation of the ACE inhibitor [Lisinopril]...."</p> <p>The resident's record lacked documentation indicating the Physician had been made aware of the pharmacy's potential drug interactions report.</p> <p>In an interview with the DON (Director of Nursing) on 4/10/14 at 9:27 A.M., she indicated she did not think the physician had been made aware of this recommendation from the pharmacy because he usually initialed documentation he had reviewed and the document lacked his initials.</p> <p>2. The clinical record for Resident #5 was reviewed on 4/10/14 at 10:25 A.M. Diagnoses included, but were not limited to, dementia without behavior disturbance, atrial fibrillation, recent right embolic stroke with embolectomy and mild residual left hemiparesis, dysphagia with a PEG (percutaneous endoscopic gastrostomy) tube, hypertension, and congestive heart failure.</p> <p>The April, 2014 physician's order recap (recapitulation) sheet included the following order:</p> <p>2/11/14--Metoprolol (an anti-hypertensive medication) 25 mg. (milligrams), one tablet by PEG tube 2 times a day; "Hold for SBP [systolic blood pressure] < [less than] 110 or HR [heart rate] < 60." The medication was scheduled for 9 A.M. and 9 P.M.</p>		<p><u>to ensure the practice does not recur?</u> The DON or RCD will audit current resident records 5 days per week as part of her routine beginning 5/6/14. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee meeting. This will continue for 3 months or until a pattern of compliance is established beginning 5/6/14.</p>				

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	<p>The February, March, and April, 2014 MAR (Medication Administration Record) listed this order as prescribed, including the parameters for holding the medication if the systolic blood pressure was less than 110 and heart rate less than 60. The medication was first administered on 2/12/14 at the 9 A.M. dose.</p> <p>There were no blood pressures or heart rates documented on the MARs.</p> <p>The "Vital Signs and Weight Record" had documentation of blood pressures, temperatures, pulses, and respiration rates from 2/10/14, when the resident was admitted, to 4/10/14.</p> <p>There were no blood pressure measurements documented for March 6, 7, 12, and 26. There were 21 days that had only one entry for a blood pressure. Of the 88 blood pressure measurements that were documented, 85 listed the time frame the blood pressure was checked as either "7 AM-7 PM" or 7 PM-7 AM." There was no indication the resident's blood pressure had been checked prior to the administration of the Metoprolol at 9 A.M. or 9 P.M., in order to know if that dose of medication needed to be held.</p> <p>There were 13 blood pressure measurements listed on the "Vital Signs" sheet that met the "Hold" parameters, as follows:</p> <p>2/12/14--102/70 2/14/14--90/61 2/15/14--102/76 2/18/14--107/68 2/22/14--93/61</p>						

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F000371 SS=F	<p>2/28/14--97/61 3/1/14--107/68 3/16/14--89/66 3/16/14--100/60 3/28/14--107/74 4/3/14--98/63 4/6/14--102/63</p> <p>The MAR had one entry on 2/14/14 that appeared to be circled, indicating the medication had not been given. An entry on the reverse side for that dated indicated "G-Tube Metoprolol 25 mg. held due to BP [blood pressure]." The entry was crossed out, and "error" with a nurse's initials were written at the end of the entry.</p> <p>All other doses of the Metoprolol were administered on the days the resident's blood pressure, at some time during the day or evening, was below the "Hold" parameter of 110 for a systolic blood pressure.</p> <p>During an interview on 4/10/14 at 10:22 A.M., LPN #3 indicated blood pressure measurements would be documented on the "Vital Sign Sheet." She indicated she checked the resident's blood pressure before she gives the BP medication. She did not, however, document the actual time she checked the blood pressure, but just documented that it was taken on the "7 A to 7 P" shift.</p> <p>3.1-48(a)(3) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>						

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	<p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to assure that unused preparation equipment was covered and used and unused ovens were kept clean. This deficient practice had the potential to affect 12 of 13 residents residing at the facility's skilled area who were served food from the kitchen.</p> <p>Findings include:</p> <p>During an initial sanitation tour of the kitchen with the kitchen manager on 4/7/14 at 9:50 A.M., a radio was observed sitting on the receiving end of an uncovered meat slicer. The radio had visible white debris on the top.</p> <p>In an interview at that time the kitchen manager indicated the radio should not be on the meat cutter, and he was not sure why it was there.</p> <p>On 4/7/14 at 10:00 A.M., during the initial kitchen sanitation tour an oven deemed as, "not being used" and one being used were observed with black bubbly shaped debris on the bottom and general build up of dark residue through out the ovens.</p> <p>In an interview with the kitchen manager at that time, he indicated the ovens were cleaned regularly.</p> <p>During an observation with Cook # 7, of the two ovens on 4/10/14 at 11:10 A.M., the ovens were again observed to have dark bubble shape debris on the bottom and general dark build up.</p>	F000371	<p><u>What corrective action will be taken by the facility?</u> The RD will educate the CDM on the sanitation audit process and deep cleaning schedules by 4/30/14. The CDM will educate the dietary staff regarding the covering of kitchen equipment when not in use and the cleaning of the ovens by 5/5/14. A new daily and weekly deep cleaning schedule will be implemented on 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. CDM will conduct a sanitation audit of the main kitchen on a weekly basis and the RD will audit on a monthly basis.</p> <p><u>What measures will be put into place to ensure the practice does not recur?</u> The CDM will continue sanitation monitoring on a weekly basis and the RD on a monthly basis. She will bring any identified issue to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The CDM will bring the results of the</p>		05/05/2014		

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F000514 SS=D	<p>At this time, Cook # 7 indicated the ovens are usually wiped regularly and deeper cleaned once every couple weeks. He indicated, somehow the one oven that was being used was not wiped down as scheduled.</p> <p>3.1-21(i)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCES- SIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to accurately document the weight, for 1 of 4 residents reviewed for Nutrition and weight issues. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record for Resident #21 was reviewed on 4/9/14 at 10:29 A.M. Diagnoses included, but were not limited to, history of lower extremity deep vein thrombosis, orthostatic hypotension, congestive heart failure, history of vocal cord</p>		F000514	<p>reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the CDM and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.</p> <p><u>What corrective action will be taken by the facility</u> Resident #21 – did not have weight loss as indicated in the record (the weight of the wheelchair was subtracted x 2 from the weight). Weight remains stable. Nursing staff will be educated on utilizing prior weight to indicate if a second weight needs to be obtained. The nurse will then record the weight and determine if reweigh is needed. Nursing staff will be educated by 5/5/14. The CDM will monitor the weights on a weekly basis beginning 5/5/14.</p>			

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	<p>dysfunction/esophageal stricture, dysphagia with strict NPO (no food or fluids by mouth), PEG (percutaneous endoscopic gastrostomy) tube; history of pneumonia (likely aspiration), and severe Parkinson's disease.</p> <p>Weights, listed on the "Vital Signs and Weight Record" sheet and the MAR (Medication Administration Record) sheet, were documented as follows:</p> <p>1/7/14--165 1/14/14--164 1/21/14--166 1/28/14--165 2/4/14--174 2/12/14--166 2/18/14--172 2/25/14--171 3/4/14--171 3/18/14--168 3/25/14--166 4/1/14--"138 without wheelchair"</p> <p>In an interview on 4/9/14 at 2:15 P.M., LPN #1 indicated she had not worked on the unit for awhile, and did not know anything about the resident's weights. She indicated the weight of the wheelchair should be posted on the wheelchair, and that Dietary would be reviewing the resident and his weights this week.</p> <p>In an interview on 4/9/14 at 2:20 P.M., LPN #2 indicated the resident was weighed both standing up and in a wheelchair. He indicated he was the one to do the last weight, and the resident was able to stand for him. He did not know why all weights prior to 4/1/14 were within a couple of pounds of each other. He did not question the weight he obtained, or was concerned that it was so</p>		<p>All active records will be audited by the CDM for questionable weights by 4/24/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. All active records will be reviewed to ensure that questionable weights are addressed and reweighs are obtained on a weekly basis beginning 5/6/14. <u>What measures will be put into place to ensure the practice does not recur?</u> Nurse will provide the C.N.A a list of needed weights for the day along with previous weights for comparison. Following the weighing of each resident, the nurse will document the weight in the Vitals and Weight Record. The CDM will check weights on all residents on a weekly basis as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The CDM will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any</p>				

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R000000	<p>much different than the last one he had done. He did not know how much the wheelchair weighed.</p> <p>In an interview on 4/9/14 at 2:25 P.M., the resident indicated staff had been weighing him both standing and sitting in the wheelchair. At that time his wheelchair was observed. The weight of the wheelchair was not posted on the wheelchair.</p> <p>The most current Dietary progress note was dated 3/5/14, and indicated "Current weight 171. Tube feeding was increased per MD recommendation and he has gained 6 lbs. Tube feeds also changed to overnight related to meds and therapy. Per nursing skin is intact and no edema present."</p> <p>On 4/10/14 at 10:46 A.M., the Dietary Manager was observed to weigh the resident, standing on the scale. In an interview at that time, she indicated the resident's weight was 165 pounds. She indicated she didn't think the LPN who had obtained the weight of 138 had done it correctly. She could not determine what happened, but felt the weight of 138 was not correct, since all previous weights had been in line with the one just taken.</p> <p>3.1-50(a)(2)</p>			R000000	<p>recommendation made by the committee will be followed up by the CDM and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.</p>		
R000273	<p>The following Residential deficiencies were cited in accordance with 410 IAC 16.2-5. 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and</p>						

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	<p>local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to assure that unused preparation equipment was covered and used and unused ovens were kept clean. This deficient practice had the potential to affect 29 of 29 residents residing in the residential section of the facility who were served food from the kitchen. Findings include: During an initial sanitation tour of the kitchen with the kitchen manager on 4/7/14 at 9:50 A.M., a radio was observed sitting on the receiving end of an uncovered meat slicer. The radio had visible white debris on the top. In an interview at this time, the kitchen manager indicated that the radio should not be on the meat cutter and he was not sure why it was there. On 4/7/14 at 10:00 A.M., during the initial kitchen sanitation tour an oven deemed as, "not being used" and one being used were observed with black bubbly shaped debris on the bottom and general build up of dark residue through out the ovens. In an interview with the kitchen manager at that time, he indicated the ovens were cleaned regularly. During an observation with Cook # 7, of the two ovens on 4/10/14 at 11:10 A.M., the ovens were again observed to have dark bubble shape debris on the bottom and general dark build up. At this time, Cook # 7 indicated the ovens are usually wiped regularly and deeper cleaned once every couple weeks. He indicated, somehow the one oven that was being used</p>	R000273	<p><u>What corrective action will be taken by the facility?</u> The RD will educate the CDM on the sanitation process and deep cleaning schedules by 4/3/014. The CDM will then educate the dietary staff regarding the covering of kitchen equipment when not in use and the cleaning of the ovens by 5/5/14. A new daily and weekly deep cleaning schedule will be implemented on 5/5/14. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by the alleged practice. CDM will conduct a sanitation audit of the main kitchen on a weekly basis and the RD will audit on a monthly basis. <u>What measures will be put into place to ensure the practice does not recur?</u> The CDM will continue sanitation monitoring on a weekly basis and the RD on a monthly basis. She will bring any identified issue to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The CDM will bring the results of the</p>		05/05/2014		

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	was not wiped down as scheduled.		reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the CDM and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.		